

Case Number:	CM15-0114084		
Date Assigned:	06/25/2015	Date of Injury:	12/19/2013
Decision Date:	07/23/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/12/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 26 year old male with a December 19, 2013 date of injury. A progress note dated April 17, 2015 documents subjective complaints (doing okay; still down three days a week, and getting angry a couple of times a week; sleeping well through the night again now; anxiety decreasing; remains essentially anhedonic; improvement in mood; still hypervigilant; still with helplessness on some days; recent additional stressor of witnessing a fatal accident), objective findings (cooperative and pleasant with interview; good eye contact; regular speech rate, rhythm, volume, and tone; linear, goal-directed, and coherent thought processes; mood is down; dysthymic, reactive affect; fair insight; good judgment and impulse control), and current diagnoses (post- traumatic stress disorder with comorbid panic disorder and depression). Treatments to date have included medications and cognitive behavioral therapy. The treating physician documented a plan of care that included Effexor, Prazosin, and continued cognitive behavioral therapy.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Effexor 75mg, #90 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Venlafaxine (Effexor).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 13, 16, 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Antidepressants.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Effexor 75 mg #90 with two refills is not medically necessary. Effexor is an anti-depressant in a group of drugs called selective serotonin norepinephrine reuptake inhibitors (SSNRI). Antidepressants are first-line option for neuropathic pain and the possibility for non-neuropathic pain. Effexor is approved for anxiety, depression, panic disorder and social phobias. Off label uses include fibromyalgia, neuropathic pain and diabetic neuropathy. In this case, the injured worker's working diagnoses are post-traumatic stress disorder; panic disorder with agoraphobia; and major depressive disorder moderate. The date of injury is December 19, 2011. The injured worker has been under the care of a therapist since October 2014. The injured worker had an initial psycho- pharmacologic evaluation December 19, 2014. The injured worker was treated with medications and received 33 sessions of cognitive behavioral therapy. The documentation provided interval history where the patient is doing well and mood is good, 8/10 best. The injured worker still has issues with anxiety, but is afraid to ask for work. The worker sleeps through the night, there are no nightmares and gets enough sleep. There is no documentation indicating objective functional improvement with ongoing Effexor 75 mg. There is no clinical indication or rationale based on objective functional improvement to support the ongoing use of Effexor 75 mg #90 with two refills. Additionally, the treating provider requested Effexor 75 mg #90 (a one month supply) with two refills. The injured worker is seen every six weeks. A three month supply is not clinically indicated. Consequently, absent clinical documentation with objective functional improvement as it relates to Effexor 75 mg to support the ongoing use of Effexor, Effexor 75 mg #90 with two refills is not medically necessary. 2. Prazosin 5mg #90 with 2 refills is not medically necessary and appropriate.

Prazosin 5mg #90 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Diabetes Chapter, Hypertension treatment and on the Non-MTUS PubMed Health, <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000625/>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682245.html>.

Decision rationale: Pursuant to MEDLINEplus, Prazocin 5 mg #90 with two refills is not medically necessary. Prazosin is used alone or in combination with other medications to treat high blood pressure. Prazosin is in a class of medications called alpha-blockers. It works by relaxing the blood vessels so that blood can flow more easily through the body. High blood pressure is a common condition and when not treated, can cause damage to the brain, heart, blood vessels, kidneys, and other parts of the body. Damage to these organs may cause heart disease, a heart attack, heart failure, stroke, kidney failure, loss of vision, and other problems. In

addition to taking medication, making lifestyle changes will also help to control your blood pressure. These changes include eating a diet that is low in fat and salt, maintaining a healthy weight, exercising at least 30 minutes most days, not smoking, and using alcohol in moderation. In this case, the injured worker's working diagnoses are post-traumatic stress disorder; panic disorder with agoraphobia; and major depressive disorder moderate. The date of injury is December 19, 2011. The injured worker has been under the care of a therapist since October 2014. The injured worker had an initial psycho- pharmacologic evaluation December 19, 2014. The injured worker was treated with medications and received 33 sessions of cognitive behavioral therapy. The documentation provided interval history where the patient is doing well and mood is good, 8/10 best. The injured worker still has issues with anxiety, but is afraid to ask for work. The worker sleeps through the night, there are no nightmares and gets enough sleep. There is no documentation indicating objective functional improvement with ongoing Effexor 75 mg. The injured worker is taking Prazosin 20 mg at bedtime. The documentation states the injured worker is sleeping through the night with no nightmares. However, the treating provider requested a three month supply with two refills. There is no clinical indication or rationale for a nine month supply of prazosin 5 mg. Based on clinical information in the medical record and the peer-reviewed evidence-based guidelines, Prazosin 5 mg #90 with two refills is not medically necessary.

Cognitive Behavioral Therapy Weekly for 15 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment; Behavioral interventions.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive behavioral therapy Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Cognitive behavioral therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, cognitive behavioral therapy weekly for 15 weeks is not medically necessary. Cognitive behavioral therapy guidelines for chronic pain include screening for patients with risk factors for delayed recovery including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after four weeks if lack of progress from physical medicine alone. Initial trial of 3 to 4 psychotherapy visits over two weeks. With evidence of objective improvement, up to 6 - 10 visits over 5 - 6 weeks (individual sessions). In this case, the injured worker's working diagnoses are post-traumatic stress disorder; panic disorder with agoraphobia; and major depressive disorder moderate. The date of injury is December 19, 2011. The injured worker has been under the care of a therapist since October 2014. The injured worker had an initial psycho- pharmacologic evaluation December 19, 2014. The injured worker was treated with medications and received 33 sessions of cognitive behavioral therapy. The documentation provided interval history where the patient is doing well and mood is good, 8/10 best. The injured worker still has issues with anxiety, but is afraid to ask for work. The worker sleeps through the night, there are no nightmares and gets enough sleep. The injured worker, as noted above, received 33 sessions of cognitive behavioral therapy (CBT). The documentation does not address whether the CBT

resulted in objective functional improvement. The guidelines recommend an initial trial of 3 to 4 psychotherapy visits over two weeks. With evidence of objective functional improvement up to 6 to 10 visits may be clinically indicated. As noted above, the injured worker receives 33 sessions of CBT. There are no compelling clinical facts in the absence of objective functional improvement to support additional CBT. Based on clinical information in the medical record and the peer-reviewed evidence-based guidelines, cognitive behavioral therapy weekly for 15 weeks is not medically necessary.